Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTH CENTRAL SURGICAL CENTER 9301 N. CENTRAL EXPRESSWAY, STE.100 DALLAS, TX 75231	MFDR Tracking #: M4-10-2110-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: FACILITY INSURANCE CORP Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Not paid according to MAR. Carrier requested implant invoices, appealed with invoices, carrier is upholding original decision"

Amount in Dispute: $31,694.49

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All the reductions of the disputed charges were made appropriately".

Response Submitted by: Facility Ins c/o Flahive, Ogden & Latson, 504 Lavaca, Ste 100, Austin, Tx 78701

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
7/1/09	64595	N/A	$1,252.39	$0.00
7/1/09	C1820	N/A	$21, 550.00	$0.00
7/1/09	C1883	N/A	$1,584.00	$0.00
7/1/09	C1778	N/A	$6,820.00	$0.00
7/1/09	C1787	N/A	$1,100.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 8/7/2009

- 198 – Payment denied/reduced for exceeded precertification/authorization.
- 16 – Claim/service lacks information which is needed for adjudication. Requests for reimbursement for surgical implants require a statement of certification as defined in per rules 134.402, 403 & 404.

Explanation of benefits dated 10/28/2009

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 16 – Claim/service lacks information which is needed for adjudication. Requests for reimbursement for surgical implants require a statement of certification as defined in per rules 134.402, 403 & 404.

Issues

1. Were the disputed services preauthorized by the requestor and did the requestor submit a copy of the preauthorization request and the preauthorization approval supporting the services rendered?
2. Does the requestor's submitted documentation support a statement of certification in accordance with rule §134.403?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied payment for CPT code 64595 (Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver) with reason code "198 - Payment denied/reduced for exceeded precertification/authorization". Review of the requestor's submitted documentation finds that no preauthorization approval from the insurance carrier for the services rendered was included in the dispute. Pursuant to rule §134.600(p)(2) Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services. The Division contacted the requestor contact, Tanika Domingeaux on 1/14/2010 asking for a copy of the preauthorization request and the preauthorization approval for the services rendered on 7/1/09. The Division received a copy of a partially legible preauthorization approval only from the requestor contact on 1/20/2010. The preauthorization approval supports a request for "DCS implant, laminotomy at T-11, pedicle …at T9 with 36 hour inpatient LOS (or less) under general anesthesia and Dr. Dossett be assisted by Dr. Bulger…. Recommendation: Approved." There is no approval for a revision/removal of peripheral/gastric neurostimulator pulse generator/receiver. Furthermore, the preauthorization approval supports start date 4/2/2009 and end date for the surgery on 6/8/2009. The services were rendered on 7/1/2009 which is outside the approved time frame according to this preauthorization approval the requestor submitted. In addition, the requestor is seeking payment for surgical implantables denied by the carrier with reason code "16 - claim/service lacks information which is needed for adjudication. Requests for reimbursement for surgical implants require a statement of certification as defined in per rules 134.402, 403 & 404". Pursuant to rule §134.403(g)(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Review of the requestor's documentation submitted in the dispute does not find a certification statement. Therefore, for the above stated reasons, additional reimbursement to the requestor for date of service 7/1/2009 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	6/29/11 Date
Authorized Signature	Medical Fee Dispute Resolution Manager	6/29/11 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.